

**2010 MEDICARE PART D
PROVIGIL®
PHYSICIAN FAX FORM**



ONLY the prescriber may complete this form. This form is for Medicare Part D requests.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information, please visit www.myrxassistant.com and search for the appropriate health plan formulary.

Today's Date: _____

PATIENT, INSURANCE and PHYSICIAN/CLINIC INFORMATION

Patient Name (First):		Last:		M:	DOB (mm/dd/yy):
Insurance ID Number:			Patient Telephone Number:		
Prescribing Physician's Name:	Physician NPI#:		Specialty:	Clinic Contact Person's Name:	
Clinic Name:			Clinic Address:		
City, State, Zip:		Clinic Phone #:	Clinic Secure Fax #:		
Is the patient a long term care facility resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the LTC facility contact's name, telephone and fax numbers					
LTC Contact Name:		LTC Phone #:		LTC Secure Fax #:	

DIAGNOSIS ICD-9 code plus description:	
MEDICATION REQUESTED:	Strength:
Dosing Schedule:	Quantity per Month:
1. Is the patient currently treated with the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes: -When was treatment with the requested medication started? _____	
-Is the patient currently taking a lower dose of the requested medication? (this request is for a higher dose) <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____	

3. Please list all medications the patient has previously tried and failed for treatment of this diagnosis . (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.) _____	

4. Please list any other medications the patient will use in combination with the requested medication for treatment of this diagnosis. _____	

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121

TOLL FREE

Fax: 800.693.6703 **Phone:** 800.693.6651

CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 800.858.0723, and return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.